

1993

GUIDE

To Health Insurance for People with Medicare

- ★ WHAT MEDICARE PAYS AND DOESN'T PAY
- ★ TYPES OF PRIVATE HEALTH INSURANCE
- ★ TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE
- ★ 10 STANDARD MEDIGAP INSURANCE PLANS

Developed jointly by the National Association of Insurance Commissioners
and the Health Care Financing Administration of the
U.S. Department of Health and Human Services.

— NOTICE —

Listed in the back of this booklet are the addresses and telephone numbers of each of the state agencies on aging and the state insurance departments. They are available to assist you with any questions you may have about private insurance to supplement Medicare. Suspected violations of the laws governing the marketing of these policies should generally be reported to your state insurance department since states are responsible for the regulation of insurance within their boundaries. There are federal penalties for certain violations concerning Medicare supplement insurance ("Medigap") policies. It is, for example, a federal offense for an insurance agent to indicate that he or she represents the Medicare program or any other federal agency in order to sell a policy. The federal toll-free telephone number for registering such complaints is:

1-800-638-6833

POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

	POLICY 1		POLICY 2		POLICY 3	
Does the policy cover:	YES	NO	YES	NO	YES	NO
Medicare Part A hospital deductible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Medicare Part A hospital daily coinsurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Hospital care beyond Medicare's 150-day limit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skilled nursing facility (SNF) daily coinsurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SNF care beyond Medicare's limits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare Part B annual deductible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Medicare Part B coinsurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician and supplier charges in excess of Medicare's approved amounts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Medicare blood deductibles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Policy Considerations

Can the company cancel or non-renew the policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What are the policy limits for covered services?	—	—	—	—	—	—
How much is the annual premium?	—	—	—	—	—	—
How often can the company raise the premium?	—	—	—	—	—	—
How long before existing health problems are covered?	—	—	—	—	—	—
Does the policy have a waiting period before any benefits will be paid? How long?	—	—	—	—	—	—

* Most states now require that these benefits be included in all newly issued Medigap policies

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New Medicare Beneficiary's Right to Medigap Coverage

Congress has established a 6-month open enrollment period for buying Medicare supplement health insurance (Medigap). The law, which became effective November 5, 1991, guarantees that for 6 months immediately following enrollment in Medicare's Medical Insurance program (Part B), persons aged 65 or older cannot be denied Medigap insurance because of health problems.

During this period, you have the choice of any of the different Medigap policies sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of your medical history, health status, or claims experience. The company can, however, impose the same preexisting conditions restrictions (see page 21) that it applies to Medigap policies sold outside the open enrollment period.

Many individuals are enrolled automatically in Part B as soon as they turn 65, or they sign up during an initial 7-month enrollment period that begins 3 months before they turn 65. If you are in this group, your Medigap open enrollment period starts as soon as your Part B coverage starts in the month you turn 65 (or shortly thereafter, depending on when you applied for Part B).

Others may delay their enrollment in Part B. If you continue to work after age 65 and choose to be covered by an employer insurance plan or are

covered under a spouse's employment-related insurance instead of by Medicare Part B, you will have a special 7-month enrollment period for Part B. It begins with the month your or your spouse's work ends or when you are no longer covered under the employer plan, whichever comes first. Your 6-month Medigap open enrollment period starts when your Part B coverage begins.

If you are 65 or older and eligible for Part B but chose not to buy it when it first became available to you, you may sign up for Part B during the annual general enrollment period from January through March. Once your Part B coverage is effective (in July of the year in which you sign up), you will have the regular 6-month guaranteed open enrollment period in which to select a Medigap policy.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are not eligible.

If you are under age 65, disabled, and enrolled in Medicare Part B, you are not eligible for open enrollment unless your state requires open enrollment for persons under 65 who qualify for Medicare because of a disability.

A more detailed explanation of the Medicare program can be found in

THE MEDICARE HANDBOOK.

*Copies are available from any Social Security Administration office,
or by writing:*

**MEDICARE PUBLICATIONS
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD. 21207.**

DEFINITIONS OF SOME MEDICARE TERMS

Actual Charge: The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge for physician services. The approved amount is taken from a national fee schedule that assigns a dollar value to all physician services covered by Medicare.

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as the total charge for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the provider after the beneficiary meets the annual Part B deductible of \$100. The beneficiary pays the other 20%.

Coinsurance: The portion or percentage of Medicare's approved amounts for covered services that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must first incur before Medicare begins payment for covered services.

Excess Charge: The difference between the Medicare-approved amount for a service or supply and the actual charge.

Limiting Charge: The maximum amount a physician may charge a Medicare beneficiary for a covered service if the physician does not accept assignment of the Medicare claim. The limit is 15% more than the fee schedule amount for nonparticipating physicians. The Medicare fee schedule amounts for nonparticipating physicians are 5% less than those for participating physicians (see page 6). Limiting charge information appears on Medicare's Explanation of Medicare Benefits (EOMB) form.

Participating Physician and Supplier: A physician or supplier who agrees to accept assignment on all Medicare claims.

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most older Americans covered by Medicare, there are aspects of the federal health insurance program that you find complex and confusing. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This booklet will give you a better understanding of your Medicare benefits, identify the gaps in your Medicare coverage, and provide tips on shopping for private health insurance to fill those gaps. As a Medicare beneficiary, you probably are already aware that Medicare does not cover all of your potential health care costs. For example, you are responsible for Medicare's deductibles and coinsurance, and for charges for services not covered by Medicare.

Few people can afford to pay all of those expenses out of their own funds, so they rely on supplemental insurance to cover some of the costs. As you seek to minimize your liability for health care services, you will find that there are three basic ways of doing so: (1) through the purchase of Medicare supplement insurance, which is also called "Medigap" or "Medsup" insurance; (2) by enrolling in a "coordinated care" plan, such as a health maintenance organization (HMO), that has a contract to serve Medicare beneficiaries; and (3) by continuing coverage under an employer-provided health insurance policy, if you are eligible for such protection. In addition, for beneficiaries who qualify, some costs may be covered by state Medicaid programs.

Each of these ways will be discussed in subsequent sections. Special attention will be devoted to employer plans and Medigap insurance, which most Medicare beneficiaries purchase. Medigap insurance was changed in 1992 to make it easier for consumers to compare policies and premiums.

Now, in place of a multitude of policies that varied widely in benefits and premiums there are 10 standard Medigap plans.

Insurance Counseling

Although the information in this booklet will help you to be a better informed and more careful purchaser, you may wish to obtain additional information before buying health insurance. Good sources are local senior citizen organizations or governmental agencies that have insurance counseling services.

In particular, all states except Mississippi either already offer insurance counseling or are in the process of establishing programs. The telephone numbers of insurance counseling offices in operation at press time are listed by state in the directory of state insurance departments and agencies on aging beginning on page 23.

If there is not a listing for your state's insurance counseling office, check with either the state department of insurance or agency on aging to find out when counseling services will be available. Insurance counseling can help you select the insurance that best meets your needs and fills some of the gaps in your Medicare coverage.

Before discussing the 10 standard Medigap plans and the other types of private insurance available to supplement Medicare, it will be helpful to review your Medicare benefits and identify the payment gaps.

WHAT IS MEDICARE?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). The Social Security Administration, also a part of HHS, provides information about the program and handles enrollment.

Two Parts of Medicare

Medicare has two parts--Hospital Insurance (Part A) and Medical Insurance (Part B). Part A is financed through part of the Social Security (FICA) tax paid by workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems or worked a sufficient period of time in federal, state, or local government employment to be insured.

If you do not qualify for premium-free Part A benefits, you may purchase the coverage if you are at least age 65 and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and you still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. The Part A monthly premium in 1993 is \$221.

Part B is optional and is offered to all beneficiaries when they become entitled to Part A. It also may be purchased by most persons age 65 or over who do not qualify for premium-free Part A coverage. The Part B premium in 1993 is \$36.60 each month.

You are automatically enrolled in Part B when you become entitled to Part A unless you state that you don't want it. Although you do not have to purchase Part B, it is an excellent buy because the federal government pays about 75 percent of the program costs. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your coverage started. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, skilled nursing facility or

psychiatric hospital, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for durable medical equipment supplied under the home health benefit.

Benefit Periods

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, all Part A benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits that were used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges (over the deductible) for covered hospital services during the first 60 days of a benefit period. The Part A deductible in 1993 is \$676 per benefit period. You are responsible for the deductible.

For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of \$169 a day in 1993. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you need more than 90 days of inpatient hospital care in a benefit period. When a reserve day is used, Part A pays for all covered services except for coinsurance of \$338 a day in 1993. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps in Medicare Inpatient Hospital Coverage:

- You pay \$676 deductible on first admission to hospital in each benefit period.
- You pay \$169 daily coinsurance for days 61 through 90.
- You pay \$338 daily coinsurance for each "lifetime reserve day" used.
- Coverage beyond 90 days in any benefit period is limited to the number of lifetime reserve days available and that you use.
- No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part B, it does not have to be met under Part A.
- No coverage for a private hospital room, unless medically necessary, or for a private duty nurse.
- No coverage for personal convenience items, such as a telephone or television in a hospital room.
- No coverage for care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.
- No coverage for care received outside the U. S. and its territories, except under limited circumstances in Canada and Mexico.

Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such

as a hospital. Medicare benefits are payable only if you require daily skilled care which, as a practical matter, can only be provided in a SNF on an inpatient basis, and the care is provided in a SNF certified by Medicare. Medicare will not pay for your stay in a SNF if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

To qualify for Medicare coverage for SNF care, you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. You must be admitted to the SNF for the same condition for which you were treated in the hospital and generally the admission must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and receive, skilled nursing or skilled rehabilitation services on a daily basis.

Medicare can help pay for up to 100 days of skilled care in a SNF during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance in 1993 is \$84.50. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Gaps in Medicare Skilled Nursing Facility Coverage:

- You pay \$84.50 daily coinsurance for days 21 through 100 in each benefit period.
- No coverage beyond 100 days in a benefit period.
- No coverage for care in a nursing home, or in a SNF not certified by Medicare, or for just custodial care in a Medicare-certified SNF.
- No coverage for the 3-pint blood deductible (see list of gaps under inpatient hospital care).

Home Health Care

Part A fully covers medically necessary home health visits if you are homebound, including part-time or intermittent skilled nursing services. A Medicare-certified home health agency can also furnish the services of physical and speech therapists.

Should you require speech or physical therapy, or intermittent skilled nursing services, are confined to your home, and are under the care of a physician, Part A can also pay for other services. They include necessary part-time or intermittent home health aide services, occupational therapy, medical social services, and medical supplies. Coverage is also provided for a portion of the cost of durable medical equipment (DME) provided under a plan-of-care set up and overseen by a physician.

Gaps in Medicare Home Health Coverage:

- No coverage for full-time nursing care.
- No coverage for drugs, or for meals delivered to your home.
- You pay 20% of the Medicare-approved amount for DME, plus charges in excess of the approved amount on unassigned claims.
- No coverage for homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare beneficiaries certified as terminally ill may choose to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. If you enroll in a Medicare-certified hospice program, you will receive medical and support services necessary for symptom management and pain relief. When these

services—which are most often provided in your home—are furnished by a Medicare-certified hospice program, the coverage includes: physician services, nursing care, medical appliances and supplies (including drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services.

Medicare's Part A and Part B deductibles do not apply to services and supplies furnished under the hospice benefit. You must pay only limited charges for outpatient drugs and inpatient respite care. In the event you require medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps in Medicare Hospice Coverage:

- You pay limited charges for inpatient respite care and outpatient drugs.
- You pay deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Psychiatric Hospital Care

Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days (or have used fewer than 190 days but have exhausted your inpatient hospital coverage), Part A doesn't pay for any more inpatient care in a psychiatric hospital.

However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Gaps in Medicare Inpatient Psychiatric Hospital Care:

- No coverage for care after you have received 190 days of such specialized treatment in your lifetime (even if you have not yet exhausted your inpatient hospital coverage).

MEDICARE MEDICAL INSURANCE (PART B) BENEFITS

Part B helps pay for medically necessary physician services no matter where you receive them—at home, in the doctor's office, in a clinic, nursing home, or hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the in-home use of durable medical equipment, such as wheelchairs and hospital beds.

Additionally, Part B covers physical therapy, occupational therapy, and speech pathology services in a doctor's office, as an outpatient, or in your home. Mental health services are covered along with mammograms and Pap smears. And if you qualify for home health care but do not have Part A, then Part B pays for all covered home health visits.

Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished hospice enrollees, non-self administrable drugs provided as part of a physician's services, and special drugs, such as drugs furnished during the first year after an organ transplantation and erythropoietin for home dialysis patients.

When you use your Part B benefits, you will be required to pay the first \$100 (the annual deductible) each calendar year. The deductible must represent charges for services and supplies covered by Medicare. It also must be based on the Medicare approved amounts, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Medicare Part B generally pays 80 percent of the Medicare-approved amount for covered services you receive the rest of the year. You are responsible for the other 20 percent. You have no deductible or coinsurance for home health services. You do, however, have to pay 20 percent of the Medicare-approved amount for durable medical equipment supplied under the home health benefit.

If a doctor or supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount, you are generally liable for the difference. The difference to be paid is called the "excess charge" or "balance billing." You should be aware, however, that there are certain charge limitations mandated by federal law (discussed below) and that some states also limit physician charges.

Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on a national fee schedule. The schedule assigns a dollar value to each physician service based on work, practice costs and malpractice insurance costs. Under the new payment system, each time you go to a physician for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians and medical suppliers whether they accept assignment of Medicare claims.

Accepting Assignment

Those who take **assignment** on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by the Medicare carrier, except for the deductible and coinsurance amounts that you must pay. For example, for your first annual visit, if you go to a participat-

ing physician, or if you go to a nonparticipating physician who accepts assignment, and the Medicare-approved amount for the service you receive is \$200, you will be billed \$120: \$100 for the annual deductible plus 20 percent of the remaining \$100, or \$20. Medicare would pay the other \$80. Having met the deductible for the year, the next time you used Part B services furnished by a physician or medical supplier who accepts assignment, you would be responsible for only 20 percent of the Medicare-approved amount.

Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in *THE MEDICARE PARTICIPATING PHYSICIAN/SUPPLIER DIRECTORY*. The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, all hospitals, and all state and area offices of the Administration on Aging. The directory may also be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area (see the back of *THE MEDICARE HANDBOOK* for the list of carrier addresses), or you can call the carrier for the names of Medicare-participating physicians or suppliers.

While your physician or supplier may not be a Medicare-participating physician or supplier, ask before you receive any services whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. Regardless of whether your physicians and suppliers accepted assignment, they are required to file your Medicare claim for you. However, if they don't accept assignment, you are responsible for paying all permissible charges. Medicare will then reimburse you its share of the approved amount.

In certain situations nonparticipating providers of services are required by law to accept assignment. For instance, all physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 19).

Physician Charge Limits

Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge for covered services. The most these physicians can charge for services covered by Medicare is 115 percent of the fee schedule amount for nonparticipating physicians.

Physicians who knowingly, willfully, and repeatedly charge more than these amounts are subject to sanctions. If you think you have been overcharged, or you want to know what the limiting charge is for a particular service, contact your Medicare carrier. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form that you generally receive when you go to a physician for a Medicare-covered service. You do not have to pay charges that exceed the legal limit.

If you think your doctor has exceeded the charge limit, you should contact the doctor and ask for a reduction in the charge, or a refund, if you have paid more than the charge limit. If you cannot resolve the issue with the doctor, you can call your Medicare carrier and ask for assistance.

Another federal law requires doctors who do not accept assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be \$500 or more. If the doctor did not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount.

You should also be aware that any nonparticipating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary and thus will not pay for, is required to so notify you in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps in Medicare Coverage for Doctors and Medical Suppliers

- You pay \$100 annual deductible.
- Generally, you pay 20% coinsurance.
- You pay legally permissible charges in excess of the Medicare-approved amount for unassigned claims (see page 6).
- You pay 50% of approved charges for most outpatient mental health treatment.
- You pay all charges in excess of Medicare's maximum yearly limit of \$600 for independent physical or occupational therapists.
- No coverage for most self-administerable prescription drugs or immunizations, except for pneumococcal and hepatitis B vaccinations.
- No coverage for routine physicals and other screening services, except for mammograms and Pap smears.
- No coverage for hearing aids or routine hearing loss examinations.
- No coverage for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- No coverage for dental care or dentures.
- No coverage for acupuncture treatment.
- No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.
- No coverage for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a podiatrist or doctor of medicine.
- No coverage for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.
- No coverage for routine eye examinations or eyeglasses, except prosthetic lenses, if needed, after cataract surgery.

Medicare Benefit Charts

As you can see from the preceding information, Medicare does not pay the entire cost for all services covered by the program. You or your Medicare supplemental insurance company must pay certain deductibles and coinsurance amounts and charges in excess of Medicare's approved amount for covered services and supplies.

The charts on pages 8 and 9 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but \$676	\$676
	61st to 90th day	All but \$169 a day	\$169 a day
	91st to 150th day*	All but \$338 a day	\$338 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days, enter a Medicare-approved facility generally within 30 days after hospital discharge, and meet other program requirements. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$84.50 a day	up to \$84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
	As long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
HOSPICE CARE Full scope of pain relief and support services available to the terminally ill.	Blood	All but first 3 pints per calendar year.	For first 3 pints. ***

* 60 reserve days may be used only once.

** These figures are for 1993 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row or remain in a skilled nursing facility but do not receive skilled care there for 60 days in a row.

(2) Neither Medicare nor Medicaid insurance will pay for most nursing home care.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after \$100 deductible); 50% of approved charges for most outpatient mental health services.	\$100 deductible,* plus 20% of approved amount and charges above approved amount.** 50% of approved charges for mental health services.
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Reasonable and necessary services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	80% of approved amount (after \$100 deductible).	Subject to deductible plus 20% of billed amount.
BLOOD	Blood	80% of approved amount (after \$100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after \$100 deductible).***

* Once you have had \$100 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.

** The amount by which a physician's charge can exceed the Medicare-approved amount is limited by law (see page 6).

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

TYPES OF PRIVATE HEALTH INSURANCE

Whether you need private health insurance in addition to your Medicare protection is a decision that only you can make. As you saw from the review of your Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance can help fill many of the gaps. But before buying insurance to supplement your Medicare benefits, make sure you need it. Not everyone does (see page 19).

In general it is advisable to buy the additional protection that private health insurance can provide. If you decide to buy supplemental insurance, shop carefully and buy a policy that offers the kind of additional help you think you need most. Do not be misled by the claims of a private insurer or a private insurance agent that you will be “fully” protected by buying private insurance.

A variety of private insurance policies is available to help pay for medical expenses, services and supplies that Medicare covers only partly or not at all. The basic types of policies include: (1) Medicare supplement (Medigap) policies, which pay some of the money amounts that Medicare does not pay for covered services; (2) coordinated care plans (these include health maintenance organizations [HMOs] and competitive medical plans [CMPs]), from which you purchase health care services directly for a fixed monthly premium; (3) continuation or conversion of an employer-provided or other policy you have when you reach 65; (4) nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home or at-home care; (5) hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; and, (6) specified disease policies, which pay only when you need treatment for the disease insured against.

Medigap

Medigap insurance is regulated by federal and state law and must be clearly identified as Medicare supplement insurance. It is designed specifically to complement Medicare’s benefits by filling in some

of the gaps in Medicare coverage. Medigap policies pay most, if not all, coinsurance amounts and may provide coverage for Medicare’s deductibles. Some policies also pay for limited health services not covered by Medicare, such as outpatient prescription drugs.

Note that the definition of a Medigap policy under federal law does not include all insurance products that may help you cover out-of-pocket costs. For example, a health plan offered by a company for current or former employees, or by a labor organization for current or former members, does not have to satisfy federal requirements that are applicable to Medigap insurance. Moreover, limited benefit plans, such as hospital indemnity insurance (discussed below) are not Medigap insurance. Similarly, coverage provided to individuals enrolled in coordinated care plans such as health maintenance organizations (HMOs), pursuant to contracts or agreements with the federal government, does not meet the definition of Medigap insurance even though some of the coverage may be similar. (The Medigap requirements do, however, apply to supplemental insurance products HMOs may sell to individual Medicare beneficiaries who are not enrolled under a federal contract or agreement.)

Unlike some types of health coverage that restrict where and from whom you can receive care, most Medigap policies pay the same supplemental benefits regardless of your choice of health-care provider. If Medicare pays for a service, wherever provided, the standard Medigap policy must pay its regular share of benefits. The only exception is Medicare SELECT, discussed on page 15.

When shopping for a Medigap policy, compare benefits and premiums and be satisfied that the insurer is reputable before buying. And in selecting the benefits that meet your needs, remember that Medicare pays only for services it determines to be medically necessary and only the amount it determines to be reasonable. Some of the 10 standard Medigap plans pay for limited services not covered by Medicare and some pay for charges in excess of Medicare’s approved amount.

10 Standard Medigap Plans: New regulations that went into effect on or before July 30, 1992, in nearly all states, U.S. territories, and the District of Columbia generally limit the number of different Medigap policies that can be sold in any of these jurisdictions to no more than 10 standard benefit plans (see page 12).

One of the 10 standard plans, which were developed by the National Association of Insurance Commissioners and incorporated into federal law, is a "core" benefit package (Plan "A"). Each of the other nine includes the core package plus a different combination of benefits. Insurers are not permitted to change the combination of benefits in any of the 10 standard plans or to change the letter designations that range from "A" to "J." They may, however, add names or titles to the letter designations.

While a state may limit the number of plans available in the state to fewer than 10-- and some have--each state must allow the sale of Plan A. Just as states are not required to approve all 10 plans, Medigap insurers are not required to offer all of the plans approved for sale in each of the states in which they do business. Each Medigap insurer must, however, offer Plan A.

Each of the 10 plans must cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. To make it easier for consumers to compare plans and premiums, the same format, language, and definitions must be used in describing the benefits of each of the 10 standard plans. A uniform chart and outline of coverage also must be used to summarize those benefits. With standardization, each company's products are alike, so they are competing on service, reliability and price.

Besides the standardized benefit plans, federal law permits states to allow an insurer to add "new and innovative benefits" to a standardized plan that otherwise complies with applicable standards. Any such new or innovative benefits must be cost-ef-

fective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplification.

The new Medigap regulatory programs are in effect in all jurisdictions except Montana, Oregon, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. The Montana and Oregon legislatures, which did not meet in 1992, are expected to complete action early in 1993 on Medigap regulatory programs. Until the new regulations are adopted, non-standard policies may continue to be sold along with the 10 standard plans in both Montana and Oregon.

Waivers were granted to Minnesota, Massachusetts, and Wisconsin because they already had their own standardization programs for Medigap insurance. If you live in one of these states, you should contact the state insurance department to find out what Medigap coverage is available to you. In these states, new regulatory programs are in effect, but the benefit packages are different than the 10 standard plans.

All jurisdictions that have the new regulations in force, except Delaware, Pennsylvania and Vermont, permit the sale of all 10 Medigap benefit plans. Delaware does not permit plans C, F, G and H, and Pennsylvania and Vermont do not permit Plans F, G and I.

Under the new regulations, all Medigap plans must have a loss ratio of at least 65 percent for individual policies and 75 percent for group policies. This means that on average either 65 cents or 75 cents of each premium dollar goes for benefits.

Older Medigap Policies: The new federal requirements generally do not apply to Medigap policies in force in a state before the new requirements took effect in that state. Depending on which state you live in, you will not have to switch to one of the new standardized plans if you have an older policy that is guaranteed renewable. Some states, however, have specific requirements that affect existing non-standard policies. For example, some states require or permit insurers to (continued on page 15)

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these core benefits:

- Coverage for the Part A coinsurance amount (\$169 per day in 1993) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount (\$338 per day in 1993) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount) after \$100 annual deductible is met.

PLAN B includes the core benefits *plus*:

- Coverage for the Medicare Part A inpatient hospital deductible (\$676 per benefit period in 1993).

PLAN C includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount (\$84.50 per day for days 21 through 100 per benefit period in 1993).
- Coverage for the Medicare Part B deductible (\$100 per calendar year in 1993).
- Coverage for medically necessary emergency care in a foreign country.

PLAN D includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery. The at-home recovery benefit pays up to \$1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

PLAN F includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 100% of Medicare Part B excess charges.*

PLAN G includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 80% of Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery (see Plan D).

PLAN H includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible (this is called the “basic” prescription drug benefit).

PLAN I includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 100% of Medicare Part B excess charges.*
- Basic prescription drug coverage (see Plan H for description).
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery (see Plan D).

PLAN J includes the core benefits *plus*:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care (see Plan E).
- Coverage for at-home recovery (see Plan D).
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible (this is called the “extended” drug benefit).

* Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve Days(91-150)	X	X	X	X	X	X	X	X	X	X
365 Life Hosp. Days-100%	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance-20%	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	A	B	C	D	E	F	G	H	I	J
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								1	1	2
Preventive Medical Care					X					X

Core Benefits pay the patient's share of Medicare's approved amount for physician services (generally 20%) after \$100 annual deductible, the patient's cost of a long hospital stay (\$169/day for days 60-90, \$338/day for days 91-150, approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. a "basic" benefit with \$250 annual deductible, 50% coinsurance and a \$1,250 maximum annual benefit (Plans H and I above), and
2. an "extended" benefit (Plan J above) containing a \$250 annual deductible, 50% coinsurance and a \$3,000 maximum annual benefit.

Each of the 10 plans has a letter designation ranging from "A" through "J". Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans, they all must make Plan A available if they sell any of the other 9 in a state.

convert older policies to the new standardized plans. Check with your state insurance department to find out what state-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the new Medigap policies if it is to your advantage and an insurer is willing to sell you one.

If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide superior coverage, especially for prescription drugs and extended skilled nursing care.

If you had the old Medigap policy at least 6 months and you decide to switch, the new policy is not permitted to impose a waiting period for a preexisting condition if you satisfied a waiting period for a similar benefit under your old policy. If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to 6 months--unless prohibited by your state--may be applied to that particular benefit.

Because it is unlawful for anyone to sell you insurance that duplicates coverage you already have, and because you do not need more than one Medigap policy, you must sign a statement that you intend to replace your current policy and will not keep both policies. Do not cancel the old policy until the new one is in force and you have decided to keep it (see "Free Look," page 22).

Carrier Filing of Medigap Claims. Under certain circumstances, you may not have to file a separate claim with your Medigap insurer in order to have payment made directly to your physician or medical supplier.

By law, your Medicare carrier must send your claim to the Medigap insurer when the following three conditions are met for a Medicare Part B claim: (1) your physician or supplier must have signed a participation agreement with Medicare to accept assign-

ment of Medicare claims for all patients who are Medicare beneficiaries; (2) your policy must be a Medigap policy; and (3) you must instruct your physician to indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating physician or supplier. Your physician will put your Medigap policy number on the Medicare claim form.

When these conditions are met, your Medicare carrier will process the Medicare claim, send the claim to the Medigap insurer and generally send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your physician or medical supplier and send you a notice that they have done so.

If the insurer refuses to pay the physician directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact your local Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the carrier for your area.

Medicare SELECT. A new Medicare supplement health insurance product called "Medicare SELECT" is permitted to be sold in Alabama, Arizona, California, Florida, Indiana, Kentucky, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin.

Medicare SELECT, which may be offered in the designated states by insurance companies and health maintenance organizations (HMOs), is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard Medigap plans (see page 12).

The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT policies will only pay full supplemental benefits if covered services are obtained through specified health care professionals. Medicare SELECT policies are expected to have lower premiums because of this limitation. The specified health care

professionals, called "preferred providers," are selected by the insurance company or HMO. Each issuer of a Medicare SELECT policy makes arrangements with its own network of preferred providers.

If you have a Medicare SELECT policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay the full supplemental benefits provided for in the policy. Medicare SELECT insurers must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network.

In general, Medicare SELECT policies deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges if the services you receive outside the network are services covered by Medicare.

During 1992 through 1994, Medicare SELECT policies will be evaluated to determine if they should be made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the policies are discontinued. If the program is not extended, Medicare SELECT policyholders will have the option to purchase any standard Medigap policy that the insurance company or HMO offers, if in fact it issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similar benefits.

Coordinated Care Plans That Contract With Medicare

Coordinated care plans, also called managed care and prepayment plans, include health maintenance organizations (HMOs) and competitive medical plans (CMPs). They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they arrange for health care.

As a Medicare beneficiary, you can choose how you will receive hospital, doctor, and other health care

services covered by Medicare. You can receive them either through the traditional fee-for-service delivery system or through a coordinated care plan that has a contract with Medicare. If you choose fee-for-service care, you should consider purchasing Medigap insurance. If you enroll in a Medicare-contracting HMO or CMP, you will not need a Medigap policy. In fact, insurers are prohibited from issuing you one because it would duplicate your HMO or CMP benefits. If, however, you have a Medigap policy and decide to enroll in a plan, you may keep the policy for a short time while you decide if you like the plan.

Should you enroll in a coordinated care plan and later disenroll and return to fee-for-service care, you likely will be able to buy a Medigap policy, but you may not get the policy of your choice, especially if you have a health problem. On the other hand, both disabled and aged Medicare beneficiaries generally may enroll in a Medicare-contracting HMO or CMP without regard to any health problems they may have. For this and other reasons, coordinated care can be an attractive option for many beneficiaries.

A coordinated care plan generally arranges with a network of health care providers (doctors, hospital, skilled nursing facilities, etc.) to offer comprehensive, coordinated medical services to plan members on a prepaid basis. If you enroll in an HMO or CMP with a Medicare contract, services usually must be obtained from the professionals and facilities that are part of the plan. The plan must provide or arrange for all Part A and B services (if you are covered under both parts of Medicare). Some plans also provide benefits beyond what Medicare covers, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses.

Medicare makes a monthly payment to the plan to cover Medicare's share of the cost of the services you receive. Additionally, most plans charge a monthly premium and nominal copayments as services are used instead of the regular Medicare deductible and coinsurance amounts. Usually there are no other charges--no matter how many times you visit the doctor, are hospitalized, or use other covered services.

If you enroll in an HMO or a CMP that has a "risk" contract with Medicare, Medicare will not pay for non-emergency services you receive from providers outside of the HMO or CMP. That is, you must receive all your health care benefits (except in an emergency) from the HMO or CMP in order to be covered. If you enroll in a plan that has a "cost" contract with Medicare, you can receive covered services either through the plan or outside the plan. If you go outside the plan for non-emergency services, Medicare will still pay but the plan will not. In other words, you would be responsible for the same charges that you would be liable for if you were only covered by Medicare.

You are eligible to enroll in a coordinated care plan with a Medicare contract if you live in the plan's service area, are enrolled in Medicare Part B, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. The plan must enroll Medicare beneficiaries in the order of application, without health screening, during at least one open enrollment period each year.

Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. If you live in an area that is served by more than one coordinated care plan, compare benefits, costs and other features to determine which plan meets your needs. Also, determine which type of contract the plan has with Medicare.

Group Insurance

There are two principal sources of group insurance: employers and voluntary associations.

Employer Group Insurance for Retirees. Many people, upon reaching age 65, have private insurance, often purchased through their or their spouse's current employer or union membership. If you have such coverage, find out if it can be continued when you or your spouse retires. Check the price and the benefits, including benefits for your spouse. Group health insurance that is continued after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions, and

the coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance protection.

Furthermore, since employer group insurance policies do not have to comply with the federal minimum benefit standards for Medigap policies, it is important to determine what coverage your specific retirement policy provides. While the policy may not provide the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care.

Special Rules for Working People Age 65 or Over. If you are 65 or over and you or your spouse work, Medicare may be secondary payer to any employer group health plan (EGHP) coverage you have. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer plan.

Employers who have 20 or more employees are required to offer the same health benefits, under the same conditions, to employees age 65 or over and to employees' spouses who are 65 or over, that they offer to younger employees and spouses. EGHP coverage of employers of 20 or more employees is primary to Medicare.

You may accept or reject coverage under the EGHP. If you accept the employer plan, it will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, you can buy supplemental insurance but an employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary for certain people under age 65 who are entitled to Medicare based on disability (other than those with permanent kidney failure) and who have large group health plan (LGHP) coverage. An LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. This requirement applies to those who have LGHP coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must not treat any of these people differently because they are disabled and have Medicare.

The term employee here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working, but whom the employer treats as employees. Medicare determines whether an individual is considered to be an employee. Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is secondary payer to EGHPs for 18 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under an EGHP or are covered under an EGHP as dependents. EGHPs are primary payers during this period without regard to the size of the EGHP or the number of employees. The 18-month period begins with the earlier of:

- The first month in which the person becomes entitled to Medicare Part A; or
- The first month in which an individual would have been entitled to Part A if he had filed an application for Medicare benefits.

However, EGHPs may be primary for an additional 3 months, or a total of up to 21 months: the first three months of dialysis (a period during which an individual generally is not eligible for Medicare benefits) plus the first 18 months of Medicare eligibility or entitlement. After the period of up to 21 months expires, Medicare is primary payer for entitled individuals and the EGHP is secondary.

The Health Care Financing Administration pamphlet entitled *MEDICARE COVERAGE OF KIDNEY DIALYSIS AND KIDNEY TRANSPLANT SERVICES* contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or the Consumer Information Center, Department 59, Pueblo, CO 81009.

Association Group Insurance. Many organizations, other than employers, offer group health insurance coverage to their members. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices. Association group Medigap insurance must comply with the same rules that apply to other Medigap policies.

The following types of coverage are generally limited in scope and are not substitutes for Medigap insurance or coordinated care plans.

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing home as well as certain care in the home. Policies also are available to pay for care in a skilled nursing facility (SNF) after your Medicare benefits run out (see page 3 for an explanation of the Medicare benefit for skilled nursing facility care).

If you are in the market for nursing home or long-term care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy,

make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any Medigap policy, coordinated care plan, or other coverage you have. It is important to remember that custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only care of this nature that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility.

For more information about long-term care insurance, request a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105. You may also obtain a copy of the *Guide to Choosing a Nursing Home* by writing to Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, MD 21207.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount. Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have, but other group health insurance may coordinate benefits with hospital confinement indemnity insurance sold on a group basis.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

DO YOU NEED MORE INSURANCE?

Before buying insurance to supplement Medicare, ask yourself whether you need private health insurance in addition to Medicare. Not everyone does.

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. They also qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you have Medigap insurance purchased on or after November 5, 1991, and you become eligible for Medicaid, you can request that the Medigap benefits and premiums be suspended for up to two years while you are covered by Medicaid. Should you become ineligible for Medicaid benefits during the two years, your Medigap policy will be reinstated if you give proper notice and begin paying premiums again.

Qualified Medicare Beneficiary Program: Assistance for Low-Income Elderly

Limited financial assistance is available through Medicaid for paying Medicare premiums, deductibles, and coinsurance amounts for certain low-income elderly and disabled beneficiaries who are not otherwise eligible for Medicaid. If your annual income is at or below the national poverty level and your cash and savings are very limited, you may qualify for state assistance in paying Medicare's monthly premiums, deductibles and coinsurance.

The national poverty income levels for 1992 for all states except Alaska and Hawaii were \$6,810 in annual income for one person and \$9,190 for a couple. The income limits for Alaska were \$8,500 for one person and \$11,480 for a couple while the limits for Hawaii were \$7,830 for one person and \$10,570 for a couple. The limits for 1993 will be announced in February 1993. Financial resources such as bank accounts, stocks, and bonds usually cannot exceed \$4,000 for one person or \$6,000 for a couple.

Financial assistance also is available for Medicare beneficiaries with incomes from 101 to 110 percent of the poverty level. Individuals in this category are eligible only for Medicaid payment of their Medicare Part B premium, which is \$36.60 per month in 1993. If you think you qualify for state assistance in paying your Medicare expenses, contact your state or local social service agency and ask about the "Qualified Medicare Beneficiary" program. If you cannot find a telephone number for the state agency, call 1-800-638-6833 for assistance.

Coordinated Care Plan Enrollees

If you are a Medicare beneficiary enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that has a contract with Medicare, you do not need a Medigap policy (see page 16) because it likely would duplicate coverage provided by the plan.

Federally Qualified Health Center

Medicare now pays for a new group of health services, including preventive care, when provided by a federally qualified health center (FQHC). These facilities are typically community health centers, migrant health centers and health centers for the homeless. They are generally located in inner-city and rural areas.

The new services covered by Medicare only at FQHCs include routine physical examinations, screening and diagnostic tests for the detection of vision and hearing problems and other medical conditions, and the administration of certain vaccines for immunization against influenza and other diseases.

When those services are furnished at a FQHC, the \$100 annual Part B deductible does not apply (see page 5). However, if other services are provided, such as X-rays or screening mammograms, the FQHC may bill the Medicare carrier. In that case, you would be responsible for any unmet portion of the Part B deductible. As for the 20 percent Part B coinsurance, it is applicable for all FQHC services

but Public Health Service guidelines allow the FQHC to waive it in some instances. Any Medicare beneficiary may seek services at an FQHC. To find out whether one of these centers serves your area, call 1-800-638-6833.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop Carefully Before You Buy. Policies differ as to coverage and cost, and companies differ as to service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage is expensive and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. A new federal law prohibits issuing duplicative coverage to Medicare beneficiaries even if both policies would pay full benefits. The law generally prohibits the sale of a Medicare supplement policy to a person who has Medicaid or another health insurance policy that provides coverage for any of the same benefits.

Similarly, the sale of a health insurance policy is generally prohibited if it duplicates coverage of a Medicare supplement policy or Medicaid. When you buy a replacement Medigap policy, the insurer is required to obtain your written statement that you intend to cancel the first policy after the new policy becomes effective. If you are on Medicaid, insurers may not sell you a Medigap policy unless the state pays the premium. Anyone who sells you a policy in violation of these anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call 1-800-638-6833 to report suspected violations.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other coordinated care plan; buying a Medigap policy; or buying a long-term care insurance policy.

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the 6 months before the date the policy went into effect. Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you immediately for expenses connected with that problem. Medigap policies, however, are required to cover preexisting conditions after the policy has been in effect for 6 months.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another--you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them a long time. If you decide to replace your Medigap policy, you must be given credit for the time spent under the old policy in determining when any preexisting conditions restrictions expire under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy.

Prohibited Marketing Practices. It is unlawful for a company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make fraudulent or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising also is prohibited. This tactic involves mailings to identify individuals who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of

care for which payment will be made. Some insurance policies (but not Medigap policies) pay less than the Medicare-approved amounts for hospital outpatient medical services and for services provided in a doctor's office. Others do not pay anything toward the cost of those services.

Check Your Right to Renew. States now require that Medigap policies be guaranteed renewable. This means that the company can refuse to renew your policy only if you do not pay the premiums or you made material misrepresentations on the application. Beware of older policies that let the company refuse to renew on an individual basis. These policies provide the least permanent coverage. Even though your policy may be guaranteed renewable, the company may adjust the premiums from time to time. Some policies have premiums which increase as you grow older.

Be Aware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that they are from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to claim that a policy has been approved for sale in any state in which it has not received state approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your state. This is for your protection. Agents also must be licensed by your state and may be required by the state to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy the Medigap policy of their choice without conditions being imposed (see page ii). Once this open enrollment period elapses, you may be limited as to the Medigap policies available to you, especially if you have a preexisting health condition.

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who tells you that your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

Look For an Outline of Coverage. You must be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash. Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address and telephone number for your records.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without a response, contact your state insurance department.

Use the "Free-Look" Provision. Insurance companies must give you at least 30 days to review a

Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

For Your Protection

As noted above, federal criminal and civil penalties can be imposed against anyone who sells you a policy that duplicates coverage you already have unless you sign a statement declaring that the first policy will be cancelled. Or unless you have Medicaid and the state Medicaid agency pays the premium for your Medigap policy. Penalties may also be imposed for claiming that a policy meets legal standards for federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received state approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, or the Health Care Financing Administration. It also is illegal to use the names, letters, symbols or emblems of their various programs.

This law is aimed primarily at mass marketers who use this information on mail solicitations to either imply or claim that the product they are selling—whether it be insurance or something else—has either been endorsed or is being sold by the U.S. Government. The advertising literature used by these organizations is often designed to look like it came from a government agency.

If you believe you have been the victim of any unlawful sales practices, contact your state insurance department immediately. If you believe that federal law has been violated, you may call 1-800-638-6833. In most cases, however, your state insurance department can offer the most assistance in resolving insurance-related problems.

DIRECTORY OF STATE INSURANCE DEPARTMENTS AND AGENCIES ON AGING

Each State has its own laws and regulations governing all types of insurance. The insurance offices listed in the left column of this directory are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. The middle column of the directory lists the telephone number to call for insurance counseling services. Calls to an 800 number listed in this directory are free when made within the respective state.

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Alabama		
Insurance Department 135 South Union St. Montgomery, AL 36130-3401 (205) 269-3550	1-800-242-5463	Commission on Aging 770 Washington Ave., Suite 470 Montgomery, AL 36130 1-800-243-5463 (205) 242-5743
Alaska		
Division of Insurance 800 E. Dimond, Suite 560 Anchorage, AK 99515 (907) 349-1230	(907) 563-5654	Older Alaskans Commission P.O. Box C MS 0209 Juneau, AK 99811 (907) 465-3250
American Samoa		
Insurance Department Office of the Governor Pago Pago, AS 96797 011-684/633-4116		Territorial Administration on Aging Government of American Samoa Pago Pago, AS 96799 (684) 633-1251
Arizona		
Insurance Department Consumer Affairs and Investigation Div. 3030 N. Third St. Phoenix, AZ 85012 (602) 255-4783	1-800-432-4040	Dept. of Economic Security Aging & Adult Administration 1789 W. Jefferson St. Phoenix, AZ 85007 (602) 542-4446
Arkansas		
Insurance Department Seniors Insurance Network 1123 S. University 400 University Tower Bldg. Little Rock, AR 72204-5494 (501) 686-2900	1-800-852-5494	Division of Aging and and Adult Services Donaghey Plaza South 7th & Main Sts., Suite 1417 P.O. Box 1417/Slot 1412 Little Rock, AR 72203-1437 (501) 682-2441
California		
Insurance Department Consumer Services Div. 3450 Wilshire Blvd. Los Angeles, CA 90010 1-800-927-4357	1-800-927-4357	Department of Aging 1600 K Street Sacramento, CA 95814 (916) 322-3887

INSURANCE DEPARTMENT	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Division 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499	Colorado (303) 894-7499	Aging and Adult Services Dept. of Social Services 1575 Sherman St., 10th Fl. Denver, CO 80203-1714 (303) 866-3851
	Commonwealth of the Northern Mariana Islands	Department of Community and Cultural Affairs Civic Center Commonwealth of the Northern Mariana Islands Saipan, CM 96950 (607) 234-6011
Insurance Department 153 Market Street P.O. Box 816 Hartford, CT 06142-0816 (203) 297-3800	Connecticut 1-800-443-9946	Department on Aging 175 Main Street Hartford, CT 06106 1-800-443-9946 (203) 566-7772
Insurance Department 841 Silver Lake Blvd. Dover, DE 19901 (302) 739-4251	Delaware 1-800-851-3535	Division of Aging Dept. of Health and Social Services 11901 DuPont Highway New Castle, DE 19720 (302) 577-4660
Insurance Department 613 G Street, NW Room 638 P.O. Box 37200 Washington, D.C. 20001-7200 (202) 727-8009	District of Columbia (202) 724-5626	Office on Aging 1424 K Street, NW 2nd Floor Washington, D.C. 20005 (202) 724-5626 (202) 724-5622
	Federated States of Micronesia	State Agency on Aging Office of Health Services Federated States of Micronesia Ponape, E.C.I. 96941
Dept. of Insurance State Capitol, Plaza 11 Tallahassee, FL 32399-0300 1-800-342-2762 (904) 922-3100	Florida (904) 922-2073	Office on Aging & Adult Services 1317 Winewood Boulevard Building 2, Room 323 Tallahassee, FL 32399-0700 (904) 488-8922

INSURANCE DEPARTMENTS' INSURANCE COUNSELING AGENCIES ON AGING

Insurance Department 2 Martin L. King, Jr., Dr. 716 West Tower Atlanta, GA 30334 (404) 656-2056	Georgia (404) 894-5333	Office of Aging Dept. of Human Resources 878 Peachtree St., NE, Rm 632 Atlanta, GA 30309 (404) 894-5333
Insurance Department 855 W. Marine Drive P.O. Box 2796 Agana, Guam 96910 011 (671) 477-5144	Guam	Division of Senior Citizens Dept. of Public Health and Social Services P.O. Box 2816 Agana, Guam 96910 011 (671) 734-4361
Dept. of Commerce and Consumer Affairs Insurance Division P.O. Box 3614 Honolulu, HI 96811 (808) 586-2790	Hawaii (808) 586-0100	Executive Office on Aging 335 Merchant Street Room 241 Honolulu, HI 96813 (808) 586-0100
Insurance Department Public Service Dept. 500 South 10th St. Boise, ID 83720 (208) 334-4350	Idaho 1-800-247-4422	Office on Aging Statehouse, Room 108 Boise, ID 83720 (208) 334-3833
Insurance Department 320 W. Washington St. 4th Floor Springfield, IL 62767 (217) 782-4515	Illinois 1-800-548-9034	Department on Aging 421 E. Capitol Avenue Springfield, IL 62701 (217) 785-2870
Insurance Department 311 W. Washington St. Suite 300 Indianapolis, IN 46204 1-800-622-4461 (317) 232-2395	Indiana 1-800-452-4800	Dept. of Human Services 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207-7083 (317) 232-7020
Insurance Division Lucas State Office Bldg. E. 12th & Grand Sts. 6th Floor Des Moines, IA 50319 (515) 281-5705	Iowa (515) 281-5705	Dept. of Elder Affairs Jewett Bldg., Suite 236 914 Grand Avenue Des Moines, IA 50309 (515) 281-5187

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
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<p>Insurance Department 420 S.W. 9th Street Topeka, KS 66612 (913) 296-3071 1-800-432-2484</p>	<p>Kansas 1-800-432-3535</p>	<p>Department of Aging 122-S. Docking State Office Building 915 S.W. Harrison Topeka, KS 66612-1500 (913) 296-4986</p>
<p>Insurance Department 229 W. Main Street P.O. Box 517 Frankfort, KY 40602 (502) 564-3630</p>	<p>Kentucky 1-800-372-2973</p>	<p>Division of Aging Services Dept. of Social Services 275 E. Main Street Frankfort, KY 40621 (502) 564-6930</p>
<p>Insurance Department P.O. Box 94214 Baton Rouge, LA 70804-9214 (504) 342-5900 1-800-259-5301</p>	<p>Louisiana 1-800-259-5301</p>	<p>Governor's Office of Elderly Affairs 4550 N. Boulevard P.O. Box 80374 Baton Rouge, LA 70896-0374 (504) 925-1700</p>
<p>Bureau of Insurance Consumer Division State House, Station 34 Augusta, ME 04333 (207) 582-8707</p>	<p>Maine 1-800-750-5353</p>	<p>Bureau of Elder and Adult Services 35 Anthony Ave., Station 11 Augusta, ME 04333 (207) 624-5335</p>
<p>Insurance Department Complaints and Investigation Unit 501 St. Paul Place Baltimore, MD 21202-2272 (410) 333-6300</p>	<p>Maryland 1-800-243-3425</p>	<p>State Agency on Aging 301 W. Preston Street Room 1004 Baltimore, MD 21201 (410) 225-1102</p>
<p>Insurance Division Consumer Services Section 280 Friend Street Boston, MA 02114 (617) 727-7189</p>	<p>Massachusetts (617) 727-7750</p>	<p>Executive Office of Elder Affairs 1 Ashburton Place, 5th Floor Boston, MA 02108 1-800-882-20003 (617) 727-7750</p>
<p>Insurance Department P.O. Box 30220 Lansing, MI 48909 (517) 373-0220</p>	<p>Michigan (517) 373-8230</p>	<p>Office of Services to the Aging 611 W. Ottawa Street P.O. Box 30026 Lansing, MI 48909 (517) 373-8230</p>

INSURANCE DEPARTMENTS INSURANCE COUNSELING AGENCIES ON AGING

Minnesota

Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101-2362
(612) 296-4026

1-800-392-0343

Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul, MN 55155-3843
(612) 296-2770

Mississippi

Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Counseling
services not
provided at
this time.

Council on Aging
455 N. Lamar Street
Jackson, MS 39202
1-800-345-6347
(601) 359-6770

Missouri

Department of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO 65102-0690
1-800-726-7390
(314) 751-2640

1-800-726-7390

Division of Aging
Dept. of Social Services
P.O. Box 1337
615 Howerton Court
Jefferson, MO 65102-1337
(314) 751-3082

Montana

Insurance Department
126 N. Sanders
Mitchell Bldg., Rm. 270
P.O. Box 4009
Helena, MT 59604
1-800-332-6148
(406) 444-2040

1-800-332-2272

The Governor's Office
on Aging
State Capitol Building
Room 219
Helena, MT 59620
1-800-332-2272
(406) 444-3111

Nebraska

Insurance Department
Terminal Building
941 O St., Suite 400
Lincoln, NE 68508
(402) 471-2201

(402) 471-4887

Department on Aging
State Office Building
301 Centennial Mall South
Lincoln, NE 68509-5044
(402) 471-2306

Nevada

Department of Insurance
Consumer Services
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270
1-800-992-0900

(702) 687-4270

Dept. of Human Resources
Division for Aging Services
340 N. 11th St., Suite 114
Las Vegas, NV 89101
(702) 486-3545

INSURANCE DEPARTMENTS INSURANCE COUNSELING AGENCIES ON AGING

New Hampshire

Insurance Department
Life and Health Division
169 Manchester St.
Concord, NH 03301
(603) 271-2261
1-800-852-3416

(603) 271-4642

Dept. of Health and
Human Services
Division of Elderly and
Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4680

New Jersey

Insurance Department
20 West State Street
Roebbling Building
Trenton, NJ 08625
(609) 292-5360

1-800-792-8820

Dept. of Community Affairs
Division on Aging
S. Broad and Front Sts.
CN 807
Trenton, NJ 08625-0807
1-800-792-8820
(609) 292-0920

New Mexico

Insurance Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

1-800-432-2080

Agency on Aging
La Villa Rivera Bldg.
224 E. Palace Ave. 1st Fl.
Santa Fe, NM 87501
1-800-432-2080
(505) 827-7640

New York

Insurance Department
160 West Broadway
New York, NY 10013
(212) 602-0203
Outside of New York City
1-800-342-3736

1-800-342-9871

State Office for the Aging
2 Empire State Plaza
Albany, NY 12223-0001
1-800-342-9871
(518) 474-5731

North Carolina

Insurance Department
Seniors Health Insurance
Information Program (SHIIP)
P.O. Box 26387
Raleigh, NC 27611
(919) 733-0111 (SHIIP)
1-800-662-7777 (Consumer services)

1-800-443-9354

Dept. of Human Resources
Division of Aging
693 Palmer Drive
Raleigh, NC 27626-0531
(919) 733-3983

North Dakota

Insurance Department
Capitol Bldg., 5th Fl
600 E. Boulevard
Bismarck, ND 58505-0320
1-800-247-0560
(701) 224-2440

1-800-247-0560

Dept. of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58507-7070
(701) 224-2577

INSURANCE DEPARTMENTS INSURANCE COUNSELING AGENCIES ON AGING

Ohio

Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
1-800-686-1526
(614) 644-2673

1-800-686-1578

Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma

Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828

(405) 521-6628

Dept. of Human Services
Aging Services Division
312 NE 28th Street
Oklahoma City, OK 73125
(405) 521-2327

Oregon

Department of Insurance
and Finance
Insurance Division
Consumer Advocacy
440 Labor & Industries
Building
Salem, OR 97310
(503) 378-4484

(503) 378-4484

Dept. of Human Resources
Senior Services Division
500 Summer St., NE, 2nd. Floor
Salem, OR 97310
1-800-232-3020
(503) 378-4728

Palau

State Agency on Aging
Dept. of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania

Insurance Department
Consumer Services Bureau
1321 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

(717) 783-8975

Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico

Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

(809) 721-5710

Governors Office of
Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429

**Republic of the
Marshall Islands**

State Agency on Aging
Dept. of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

INSURANCE DEPARTMENTS INSURANCE COUNSELING AGENCIES ON AGING

Insurance Division 233 Richmond St., Suite 233 Providence, RI 02903-4233 (401) 277-2223	Rhode Island 1-800-322-2880	Dept. of Elderly Affairs 160 Pine Street Providence, RI 02903 (401) 277-2858
Insurance Department Consumer Assistance Section P.O. Box 100105 Columbia, SC 29202-3105 (803) 737-6140 1-800-768-3467	South Carolina 1-800-868-9095	Commission on Aging 400 Arbor Lake Drive Suite B-500 Columbia, SC 29223 (803) 735-0210
Insurance Department Enforcement 910 E. Sioux Avenue Pierre, SD 57501-3940 (605) 773-3563	South Dakota (605) 773-3656	Agency on Aging Richard F. Kneip Building 700 Governors Drive Pierre, SD 57501-2291 (605) 773-3656
Dept. of Commerce & Insurance Insurance Assistance Office 4th Floor 500 James Robertson Pkwy. Nashville, TN 37243 1-800-525-2816 (615) 741-4955	Tennessee 1-800-525-2816	Commission on Aging 706 Church Street Suite 201 Nashville, TN 37243-0860 (615) 741-20656
Department of Insurance Complaints Resolution, MC 111-1A 333 Guadalupe St., P.O. Box 149091 Austin, TX 78714-9091 (512) 463-6515 1-800-252-3439	Texas 1-800-252-9240	Department on Aging P.O. Box 12786 Capitol Station 949 U.S. Rt. 35, South Austin, TX 78741 (512) 444-2727
Insurance Department Consumer Services 3110 State Office Bldg. Salt Lake City, UT 84114 1-800-439-3805 (801) 538-3805	Utah (801) 538-3910	Division of Aging and Adult Services 120 North 200 West P.O. Box 45500 Salt Lake City UT 84103 (801) 538-3910
Dept. of Banking & Insurance Consumer Complaint Division 89 Main Street, Drawer 20 Montpelier, VT 05620-3101 (802) 828-3301	Vermont 1-800-642-5119	Office on Aging Waterbury Complex 103 S. Main Street Waterbury, VT 05671-2301 (802) 241-2400

INSURANCE DEPARTMENTS INSURANCE COUNSELING AGENCIES ON AGING

Virginia

1-800-552-4464

Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Dept. for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
1-800-552-4464
(804) 225-2271

Virgin Islands

(809) 774-2991

Insurance Department
Kongens Gade No. 18
St. Thomas, VI 00802
(809) 774-2991

Dept. of Human Services
19 Estate Diamond
Frederick Sted
St. Croix, VI 00840
(809) 772-4850

Washington

1-800-562-6900

Insurance Department
Insurance Bldg. AQ21
P.O. Box 40255
Olympia WA 98504-0255
1-800-562-6900
(206) 753-7300

Aging & Adult Services Admin.
Dept. of Social & Health Servcs.
12th and Jefferson Sts.
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia

(304) 558-3317

Insurance Department
2019 Washington St., E.
Charleston, WV 25305
(304) 348-3386
1-800-642-9004
1-800-435-7381 (hearing impaired)

Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
(304) 558-3317

Wisconsin

1-800-242-1060

Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
1-800-236-8517
(608) 266-0103

Bureau on Aging
Department of Health and
Social Services
P.O. Box 7851
217 S. Hamilton St., Suite 300
Madison, WI 53707
(608) 266-2536

Wyoming1-800-442-4333
Ext. 6888

Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
1-800-442-4333
(307) 777-7401

Division on Aging
Hathaway Building
2300 Capitol Ave., Room 139
Cheyenne, WY 82002
1-800-442-2766
(307) 777-7986

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207



U.S. Department of Health and Human Services
Health Care Financing Administration
Publication No. HCFA-02110
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